blue california

2024 Summary of Benefits

Blue Shield TotalDual Plan (HMO D-SNP)

Medicare Advantage Prescription Drug Plan
for Orange and San Bernardino Counties

Effective January 1, 2024 – December 31, 2024

blueshieldca.com/medicare

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2024 Summary of Benefits
Blue Shield TotalDual Plan (HMO D-SNP)
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The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please refer to the ***Evidence of Coverage (EOC)*** at **blueshieldca.com/MAPDdocuments2024** or by calling Customer Service at **(800) 452-4413** [TTY**: 711**], 8 a.m. to 8 p.m., seven days a week. **Note: The *EOC* will be available on our website by October 15, 2023.**

Blue Shield TotalDual Plan includes Part D coverage, which provides prescription drug coverage, offering you the convenience of having both your medical and prescription drugs covered through one plan.

To join **Blue Shield TotalDual Plan**, you must have both Medicare Part A and Medicare Part B, live in our service area, be a United States citizen or be lawfully present in the United States, and be eligible for both Medicare and Medi-Cal (Medicaid). **Our service area includes Orange and San Bernardino Counties.**

If you want to know more about the coverage and costs of Original Medicare, look in your current ***"Medicare & You"*** handbook. View it online at **www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048.**

Our plan ***Provider Directory*** is located on our website at **blueshieldca.com/medicare/providerdirectory**.

Our plan ***Pharmacy Directory*** is located on our website at **blueshieldca.com/medpharmacy2024**.

To get the most complete and current information about which drugs are covered, you can visit our website at **blueshieldca.com/medformulary2024**.

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Premiums and benefits	You pay	What you should know
Monthly plan premium	$0	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Health plan deductible	$0	
Annual out-of-pocket maximum amount	$8,850	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Part A and Part B services.
Inpatient hospital care	$0	**Prior authorization and a referral from your doctor may be required for inpatient hospital care.** Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
Outpatient hospital services • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$0 copay for each visit to an outpatient hospital facility or an emergency room $0 copay for observation services	**A referral and/or prior authorization may be required for outpatient hospital facility and observation services.** Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
Outpatient surgery	$0 copay for each visit to an ambulatory surgical center and outpatient hospital facility	**A referral and prior authorization from your doctor may be required.**
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $0 copay per visit	 **A referral from your doctor may be required for Specialist visits.**
Preventive care	$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.

Premiums and benefits	You pay	What you should know
Emergency care • Worldwide coverage	$0 copay for each Medicare-covered emergency room visit 20% coinsurance for worldwide emergency coverage (waived if admitted to the hospital within one day for the same condition) No combined annual limit for emergency care and urgently needed services outside the United States and its territories	
Urgently needed services • Worldwide coverage	$0 copay for urgently needed services 20% coinsurance for worldwide urgent coverage (waived if admitted to the hospital within one day for the same condition) No combined annual limit for emergency care and urgently needed services outside the United States and its territories	
Diagnostic services, labs, and imaging		**A referral from your doctor may be required for diagnostic services, labs, and imaging services.**
• Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.)	$0 copay for each diagnostic radiology service	Covered according to Medicare guidelines.
• Lab services	$0 copay	
• Diagnostic tests and procedures	$0 copay	

Premiums and benefits	You pay	What you should know
• Outpatient X-rays	$0 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay for each therapeutic radiology service	
Hearing services		**A referral from your doctor may be required for Medicare-covered hearing services.**
• Hearing exam (Medicare-covered)	$0 copay per visit	
• Routine (non-Medicare covered) hearing exam	$0 copay per visit	
• Hearing aids	You will be reimbursed up to $2,000 every year for two hearing aids and two hearing aid fitting and evaluations	Applies to both ears combined; costs for hearing aids do not apply to the plan's maximum out-of-pocket limit.
Dental services (Medicare-covered)	$0 copay per visit if performed by your PCP or a specialist	**A referral from your doctor may be required**
Dental services (non-Medicare covered)		
• Prophylaxis (cleaning)	$0 copay	Two visits per calendar year.
• Fluoride	$0 copay	Two visits per calendar year.
• Oral exam	$0 copay	One every three calendar years, per provider or location for oral exam.

Premiums and benefits	You pay	What you should know
Vision services		
• Exam to diagnose and treat diseases and conditions of the eye	$0 copay for each Medicare-covered visit	**A referral from your doctor may be required for an exam to diagnose and treat diseases and conditions of the eye.**
• Routine (non-Medicare covered) eye exam and refraction	$0 copay	Some coverage at non-network providers included; see the plan EOC for details. One visit every 12 months with a network provider.
• Eyeglass frames	$0 copay	Our plan pays for one pair of eyeglass frames (priced up to a regular retail value of $350) every 24 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.
• Eyeglass lenses or contact lenses	$0 copay	Our plan pays for either one pair of prescription eyeglass lenses (regardless of size or power) OR for contact lenses (priced up to $350 for contact lens service and materials) every 12 months when obtained from a network provider. Some coverage at non-network providers included; see the plan EOC for details.

Premiums and benefits	You pay	What you should know
Mental health services		**A referral and/or prior authorization from your doctor may be required for mental health services.**
• Inpatient services in a psychiatric hospital	$0 copay per Medicare-covered stay for days 1-150	If you go over the 150-day limit, you will be responsible for all costs. See plan EOC for more information.
• Outpatient individual therapy visit	$0 copay	
• Outpatient group therapy visit	$0 copay	
Skilled nursing facility (SNF) care	$0 copay per day for days 1-100	**A referral and prior authorization and prior authorization from your doctor may be required for skilled nursing facility care.** If you go over the 100-day limit, you will be responsible for all costs. No prior hospitalization required with network provider.
Rehabilitation Services		**A referral and prior authorization from your doctor may be required for rehabilitation services.**
• Occupational therapy	$0 copay per visit	
• Physical therapy	$0 copay per visit	
• Speech and language therapy	$0 copay per visit	
Ambulance services	$0 copay per trip (each way)	
Transportation services (non-Medicare covered)	$0 copay	Limited to 48 one-way trips to plan-approved health-related locations every 12 months.
Medicare Part B Prescription Drugs	$0 copay	Some Part B drugs may require a prior authorization from your provider. Insulin obtained under Part B (when taken with an insulin pump) should not exceed a $35 copay for a one-month supply.

Additional benefits included in your plan

Premiums and benefits	You pay	What you should know
Annual Physical Exam	$0 copay	One every 12 months.
Opioid Treatment Program Services	$0 copay	**A referral and prior authorization from your doctor may be required for Opioid Treatment Program Services.**
Additional telehealth services	$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
Foot care (podiatry services)		**A referral from your doctor may be required for Medicare-covered foot care services.**
• Foot exams and treatment	$0 copay for each Medicare-covered visit	
• Routine (non-Medicare covered) foot care	$0 copay for each routine (non-Medicare covered) visit	
Diabetic Supplies & Services		Prior authorization from the plan may be required for diabetic supplies and services (including blood glucose monitors). See the plan EOC for more information.
• Blood glucose monitors	$0 copay for FreeStyle® blood glucose monitors and 20% coinsurance for blood glucose monitors from all other manufacturers	
• Diabetes self-management training, diabetic services and supplies	$0 copay for all training, services and supplies except blood glucose monitors (see "Blood glucose monitors" above)	

Premiums and benefits	You pay	What you should know
Durable Medical Equipment (DME) and Related Supplies		Prior authorization from the plan may be required for DME.
• Durable medical equipment (e.g., wheelchairs, oxygen)	$0 copay	See the plan EOC for more information.
Prosthetics/Medical Supplies		**Prior authorization from your doctor may be required for prosthetics/medical supplies.**
• Prosthetics (e.g., braces, artificial limbs)	$0 copay	
• Medical supplies (e.g., splints, casts)	$0 copay	
Health and Wellness programs		
• Basic gym access through SilverSneakers Fitness	$0 copay	
• NurseHelp 24/7℠ (telephone and online support)	$0 copay	
• Personal Emergency Response System (PERS) (24/7 medical alert)	$0 copay	
Over-the-Counter (OTC) Items	You have a $180 allowance per quarter to spend on covered items	You can place two orders per quarter and cannot roll over your unused allowance into the next quarter.
Routine chiropractic services (non-Medicare covered)	$0 copay per visit	Limited to 12 visits per year.

Prescription drug coverage

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You pay the following:

Part D prescription drug benefit			
Stage 1: Annual Deductible Stage	$545 (The deductible doesn't apply to drugs listed on Tier 1, covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.)		
Stage 2: Initial Coverage Stage	**Standard retail cost-sharing (in-network)^**		
	30-day supply	**90-day supply*NDS**	**100-day supplyNDS**
Tier 1: Preferred Generic Drugs	$0 copay	See 100-day supply	$0 copay
Tier 2: Generic Drugs	$0, $1.55 or $4.50 copay	$0, $1.55 or $4.50 copay	Not Covered
Tier 3: Preferred Brand Drugs	$0, $4.60 or $11.20 copay	$0, $4.60 or $11.20 copay	Not Covered
Tier 3: Covered Insulins**	$0, $4.60 or $11.20 copay	$0, $4.60 or $11.20 copay	Not Covered
Tier 4: Non-Preferred Drugs	$0, $4.60 or $11.20 copay	$0, $4.60 or $11.20 copay	Not Covered
Tier 4: Covered Insulins**	$0, $4.60 or $11.20 copay	$0, $4.60 or $11.20 copay	Not Covered
Tier 5: Specialty Tier Drugs	$0, $4.60 or $11.20 copay	Not Covered	Not Covered

** Covered Insulins are marked with the symbol INS on the drug list. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs ("Extra Help").

^If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy. There are limited situations where you may be able to get drugs from an out-of-network pharmacy at the same cost as an in network standard retail cost-sharing pharmacy.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

*90-and 100-day supply cost-sharing also applies to Blue Shield's mail service pharmacy.

NDS A long-term (up to a 90-or 100-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol NDS in our Drug List.

Part D prescription drug benefit		
Stage 3: Coverage Gap Stage	Coverage for outpatient prescription drugs after the total yearly drug costs paid by both you and Blue Shield reach $5,030, until your yearly out-of-pocket drug costs reach $8,000.	Tier 1: Preferred Generic Drugs, Tier 3: Covered Insulins and Tier 4: Covered Insulins are covered at the copays described above. For all other tiers, you pay 25% of the price for brand-name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs until your year-to-date out-of pocket costs total $8,000, which is the end of the coverage gap stage. Whether a drug is considered generic or brand can be determined using the plan formulary.
Stage 4: Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs you bought through your retail pharmacy and through mail service) reach $8,000, the plan pays the full cost for your covered Part D drugs. (This stage **protects** you from any additional costs once you have paid your yearly out-of-pocket drug costs.)	

Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Mail Service Pharmacy

CVS Caremark® is our network mail service pharmacy where you can get a 90- or 100-day supply of maintenance drugs at a lower cost share. Your order will be delivered to your home or office with no charge for standard shipping. See plan EOC for more information.

Tier 5 drugs are limited to a 30-day supply by mail service.

Medi-Cal Covered Benefits

Effective January 1, 2024 - December 31, 2024

Medi-Cal Covered Benefits Chart
This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and Medi- Cal. How much Medi-Cal covers depends on your income, resources, and other factors.

You can only access the full list of Medi-Cal benefits if you are in one of these Medi-Cal categories:

• **Qualified Medicare Beneficiary Plus (QMB+):** You are eligible for full Medi-Cal benefits and Medi-Cal pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts. You pay nothing, except for Part D prescription drug copays.

• **Specified Low-Income Medicare Beneficiary (SLMB+):** You are eligible for full Medi-Cal benefits and Medi-Cal pays your Part B premium. Generally, your cost share is $0 when the service is covered by both Medicare and Medi-Cal. There may be cases where a service or benefit is not covered by Medi-Cal, in which case you will have to pay a cost share.

• **Full Benefits Dual Eligible (FBDE):** You are eligible for full Medi-Cal benefits and Medi-Cal may provide limited cost-sharing assistance for Medicare. Generally, your cost share is $0 when the service is covered by both Medicare and Medi-Cal. There may be cases where a service or benefit is not covered by Medi-Cal, in which case you will have to pay a cost share.

• If your category of Medi-Cal eligibility changes, your cost share and access to the below services may also change. You must recertify your Medi-Cal enrollment each year to continue your enrollment in our plan.

The following services are covered by your Medi-Cal Managed Care Plan or Medi-Cal Fee-For-Service. When services are covered by both Medi-Cal and Blue Shield TotalDual Plan, Blue Shield will pay first and Medi-Cal will pay second. Blue Shield will work with your Medi-Cal carrier to coordinate access to your full scope of benefits as a dual-eligible, but Blue Shield is not responsible for the authorization, referral, or reimbursement of the Medi-Cal covered services listed below.

The benefits listed below may have exclusions and/or limitations. For more details on Medi-Cal covered services, contact your Medi-Cal Managed Care Plan or the Department of Health Care Services' Office of the Ombudsman at **(888) 452-8609**, Monday through Friday, 8 a.m. to 5 p.m. PST, excluding holidays.

Medi-Cal Covered Benefits (cont'd)

Effective January 1, 2024 - December 31, 2024

Benefit/Service	Medi Cal	Blue Shield TotalDual
Acupuncture	Covered	Covered
Ambulance services	Covered	Covered
Anesthesiology services	Covered	Covered
Blood and blood derivatives	Covered	Covered
Chiropractic services	Covered	Covered
Chronic hemodialysis and dialysis	Covered	Covered
Community-Based Adult Services	Covered	Not Covered
Dental services	Covered	Covered
Diabetes Prevention Program	Covered	Covered
Durable Medical Equipment	Covered	Covered
Emergency and urgent services	Covered	Covered
Enhanced Case Management	Covered	Covered
Eyeglasses and contact lenses	Covered	Covered
Federally Qualified Health Center (FQHC) services	Covered	Covered
Hearing aids	Covered	Covered
Home and community-based waiver services	Covered	Not Covered
Home health agency services	Covered	Covered
Home health aide services	Covered	Covered
Hospice care	Covered	Covered
Hospital outpatient services	Covered	Covered
Human Immunodeficiency Virus and AIDS drugs	Covered	Covered
Indian health services	Covered	Not Covered
In-home Supportive Services (IHSS)	Covered	Not Covered
Inpatient hospital services	Covered	Covered
Intermediate care facility services for the developmentally disabled	Covered	Not Covered
Intermediate care services	Covered	Not Covered
Laboratory, radiological and radioisotope services	Covered	Covered
Licensed Midwife services	Covered	Covered
Long-term care	Covered	Not Covered
Multipurpose Senior Services Program (MSSP)	Covered	Not Covered
Nursing facility services	Covered	Covered
Optometry Services	Covered	Covered
Organ Transplant Services	Covered	Covered

Medi-Cal Covered Benefits (cont'd)

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Benefit/Service	Medi Cal	Blue Shield TotalDual
Outpatient clinic services	Covered	Covered
Outpatient detox services	Covered	Covered
Outpatient mental health	Covered	Covered
Over-the-counter (OTC) items	Not Covered	Covered
Pharmaceutical and prescription drug services	Covered	Covered
Physician and specialist services	Covered	Covered
Podiatry services	Covered	Covered
Prosthetics and Orthotics	Covered	Covered
Physical, occupational, speech and audiological therapy services	Covered	Covered
Rehabilitation center services	Covered	Covered
Rural health clinic services	Covered	Covered
Skilled Nursing Facility Services	Covered	Covered
Specialty mental health services	Covered	Not Covered
Substance Use Disorder Services	Covered	Covered
Transportation services	Covered	Covered
Virtual care	Covered	Covered

We're here to help

Contact Blue Shield at **(888) 534-4263** [TTY: **711**]

8 a.m. to 8 p.m., seven days a week.

Blue Shield of California is an HMO and an HMO D-SNP plan with a Medicare contract and a contract with the California State Medicaid Program. Enrollment in Blue Shield of California depends on contract renewal.

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability.

La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental.

本公司遵守適用的州法律和聯邦民權法律，並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人。

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